STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
PROVIDER AGREEMENT FORM

_____ (Provider) with the understanding that participation in the Rhode Island Department of Human Services Medical Assistance Program hereafter, "DHS" or "RIMAP" is voluntary, agrees to the following:

1. To follow all laws, rules, regulations, policies and amendments that govern the Rhode Island Medical Assistance Program as specified by the Federal Government and the State of Rhode Island.

2. To be licensed, certified, or registered as required by State and/or Federal law. The Provider will notify RIMAP within seven (7) days of any adverse action initiated against the license, certification, or registration of the provider or any of its officers, agents or employees.

3. To provide medically necessary services, goods, or products within the amount, duration, and scope of the RIMAP, to beneficiaries consistent with the provider's qualifications and adhere to professional standards governing medical care and services.

4. To maintain, for a minimum of seven (7) calendar years after the year of service, information and records necessary to determine the nature and extent of services rendered under the RIMAP and furnish them in the State of Rhode Island upon request by the Secretary of Health and Human Services (HHS), the RIMAP, and to the Department of Attorney General Medical Assistance Medicaid Fraud Control Unit. Further, the provider specifically agrees to notify the Secretary of HHS and the RIMAP, within thirty-five (35) days of any agreement or transaction relating to the provider's ownership interest in any subcontractor with whom the provider has had business transactions exceeding the lesser of $25,000 or 5% of the provider's total operating costs during the immediately preceding twelve (12) month period. In addition, the provider agrees to notify DHS of any significant business transactions including, but not limited to, any change of ownership or control interest of the provider, bankruptcy, mergers, and transaction which exceeds the lessor of $25,000 or 5% of the provider's total operating costs within any twelve (12) month period, between the provider and any wholly owned supplier or between the provider and any subcontractor within thirty-five (35) days of said transaction.

5. To accept the rates of fees and reimbursement of the RIMAP as the sole and complete payment in full for services, goods, or products delivered to beneficiaries, except for payment made from the beneficiary's applied income, authorized co-payments, cost sharing, or spend-down liability.

6. To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended, as well as all State and Federal laws that prohibit discrimination on the basis of race, sex, age, color, religion, national origin and handicap.

7. To fully exhaust the beneficiary's other medical insurance or other third party sources for payment for medical care prior to submitting Medical Assistance claims for reimbursement; to report third party payment and acknowledge the RI Medical Assistance Program as payer of the last resort; to assist the RIMAP in identifying other possible sources of third party liability for those beneficiaries who may have legal recourse to pay all or part of the medical costs.

8. To notify the Department of Human Services directly or through its fiscal agent of material and/ or substantial changes in information contained on the enrollment application given to the Department by the provider. This notification shall be made in writing within thirty-five (35) days of the event triggering the reporting obligation.

9. To bill the RI Medical Assistance Program in accordance with State and Federal regulations and laws, but in no event more than the provider's usual, customary, and reasonable rate charged to the general public for all services, goods, and products provided to Medical Assistance beneficiaries.

10. On each claim form or transmittal document for claims submitted via electronic means, to certify by signature of the provider, or if the provider is organized as a corporation, partnership, limited partnership, limited liability corporation, or other business entity, an owner, partner, director, or officer of that entity, that the goods or services listed were medically necessary, authorized (if the goods or services claimed require pre-authorization under existing statutes or regulations), and actually rendered to the RIMAP beneficiary. The Provider shall be responsible for the accuracy of claims submitted, whether in paper or electronic form. Provider acknowledges that neither the Department nor its fiscal agent bears responsibility for the review and correction of inaccuracies in any claim form or transmittal submitted by the Provider.

11. To submit claims and documentation in a form acceptable to DHS and its fiscal agent.

12. To acknowledge that administrative, civil, or criminal action may be initiated if the Provider is found in violation of RI Medical Assistance Program statutes, rules or regulations and that suspected violations must be reported by the Provider to DHS, its fiscal agent, or the Medicaid Fraud Control Unit of the Rhode Island Attorney General's Office.

13. In the event that the Department, its fiscal agent, or the Attorney General's Medicaid Fraud Control Unit determine that there is probable cause to believe that an overpayment

has been made to the Provider by inaccuracy or fraud in the Provider's submission of claims as set forth in Paragraph 10, the Provider agrees that an amount equal to the overpayment may be withheld by the Department pending investigation and/or settlement of the disputed claim.

14. To acknowledge and accept as incorporated by reference the definitions of terms included in Addendum II – Glossary Definitions.

15. To agree that any amendments or revisions to this Provider Agreement must be made in writing and signed by both parties.

16. To acknowledge and accept as incorporated Addendum I – Certification regarding debarment, suspension and other responsibility matters.

17. This is to certify that the information provided in support of this Provider Application is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws. Willful misstatement of any material fact in the application may result in criminal prosecution. I acknowledge that this is being signed under the pains and penalties of perjury and understand that the Department is relying on the accuracy of the information I have presented.

_____

Signature of Provider, Senior Partner, Chief Corporate Officer, or Authorized Agent Title Date

_____

Full Name (printed)

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Provider Number (printed)